

Pregnancy and Perinatal Loss

Summary This Guideline provides a framework to support the care of women experiencing pregnancy or perinatal loss, including practical care advice, signposting bereavement care resources, and highlighting training and support for clinicians.

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Pregnancy and Perinatal Loss

Guideline Summary

This Guideline provides a framework for health care professionals to support the immediate and subsequent compassionate bereavement care for women, their partners, and families when experiencing pregnancy or perinatal loss. It consolidates multiple sources that provide guidance about pregnancy and perinatal loss and bereavement care in NSW into an easily accessible resource.

For the purposes of this Guideline, loss includes any pregnancy loss regardless of gestation and includes neonatal death in the birth episode. Pregnancy or perinatal loss may occur through miscarriage, ectopic pregnancy, stillbirth, neonatal death, or termination of pregnancy for any indication.

Key Principles

The key principles of best practice care following pregnancy or perinatal loss include the provision of:

- trauma-informed care
- continuity of care
- empathetic communication
- emotional and practical support
- advocacy for family preferences
- coordination of associated legislative and quality improvement requirements, such as registration, investigation, reporting, review and burial, cremation or disposal arrangements
- training and support for staff providing care to women and families experiencing pregnancy or perinatal loss.

Responsibilities of Local Health Districts and Specialty Networks

Commitment to best practice care

All NSW Health services must establish and foster a commitment to delivering best practice care to women, their partners, and families who experience pregnancy or perinatal loss, irrespective of gestation or location of care. Care may be provided within maternity services or other hospital service areas where women experiencing pregnancy or perinatal loss typically present or receive care (see section 3.2).

A multidisciplinary care plan must be developed in consultation with the woman and informed by a clinical assessment and review.

Clinical pathways and midwifery support

Women experiencing the loss of a baby **from 14 weeks gestation onwards** must have midwifery and obstetric medical officer involvement in their care, including via virtual care if not available directly. This also includes follow-up midwifery care either by face-to-face visit, virtual care, or phone call within one week of discharge with consultation and referral as indicated.

Women experiencing pregnancy loss **before 14 weeks gestation** should be referred to a local early pregnancy assessment service (EPAS), where available, for ongoing clinical care and bereavement support. This may include multidisciplinary support and care. Where EPAS is not available, appropriate local pathways must be in place to ensure appropriate and timely care. This may include virtual options.

Midwifery support for the woman and for non-maternity health care professionals who are leading direct clinical care, such as providing advice to emergency department clinicians, may also be required and should be made available on request from the treating team.

System-level support

Services must provide contact details, including a direct phone line number, for a health care professional who can act as an information coordinator for families who have questions or are seeking further support after discharge home (see section 4.4).

Tiered perinatal networks have a responsibility to ensure that lower-level facilities are supported (possibly remotely) by health care professionals experienced in bereavement care to ensure equitable access for women in regional, rural, and remote locations. With the support of the higher-level facilities, all maternity and neonatal services must develop a clear model of care appropriate for their service level and facility to support women and families that aligns with best practice care (see section 4.5).

All staff who provide care to women and families experiencing pregnancy or perinatal loss must be trained appropriately and familiar with relevant policy, legislation and local pathways, and the ability to refer families to local and non-government organisations for support (see sections 4.4.1 and 5.1).

Staff wellbeing

Health care professionals involved in the care of bereaved families may suffer from vicarious trauma which can affect their capacity to provide quality care. NSW Health services must provide pathways of support to health care professionals, which may include an Employee Assistance Program (EAP) or reflective clinical supervision (see section 5.2).

Revision History

Version	Approved By	Amendment Notes
GL2025_016 October-2025	Deputy Secretary, Health System Strategy and Patient Experience	Title change to Pregnancy and Perinatal Loss. Broadened scope to include care and bereavement support for all forms of pregnancy and perinatal loss, not only stillbirths. Addition of training and support for health care professionals providing bereavement care.
PD2007_025 April-2007	Secretary, NSW Health	Title Change to Stillbirth – Management and Investigation. Inclusion of information about consent, parental information, postmortem and memory making.
GL2005_013 January-2005	Director-General	Stillbirth Investigation – Guidelines.
Circular 97/107 October-1997	Director-General	Revised Circular.
Circular 94/107 September-1994	Director-General	Original Document Guidelines for Investigation of a Stillbirth.

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1. Background

Pregnancy or perinatal loss may occur through miscarriage, ectopic pregnancy, stillbirth, neonatal death, or termination of pregnancy for any indication. When a woman and her family experience a pregnancy or perinatal loss, at any stage, there are profound effects. Women and families may experience short and long-term grief and impacts on physical and mental health, social functioning, and relationships, irrespective of the gestation when the loss occurs. Grief may also impact behaviour and changed spiritual beliefs. The impact can also be felt by the health care professionals who provide care and support to women and/or their babies, and others who support families during this time.

It is crucial that care is individualised to meet the needs of women, their partners and families who experience pregnancy or perinatal loss. Clinical care and practical considerations may differ depending on the woman's wishes and gestation. Health care professionals require appropriate training and support to effectively provide respectful, culturally safe and responsive care for women and their families.

In 2023, the overall rate of perinatal mortality (stillbirth and neonatal death) in NSW was 8.6 per 1,000 births. The rate varies amongst demographic groups; for example, the perinatal mortality rate of 12.4 per 1,000 births in Aboriginal or Torres Strait Islander mothers in 2023 is higher than the rate of 8.4 per 1,000 births experienced among babies born to non-Aboriginal or Torres Strait Islander mothers.^[1] Pregnancy loss under 20 weeks is not reported, but it is estimated that around 25% of pregnancies in Australia end in a miscarriage prior to 20 weeks gestation.^[2]

1.1. About this document

This Guideline provides a framework for best practice for health care professionals to support the care of women and families experiencing pregnancy or perinatal loss. Guidance for immediate and subsequent care in different circumstances is provided within each relevant section of this Guideline.

1.1.1. Guideline scope

The scope of this Guideline includes the immediate and subsequent compassionate bereavement care of women and families who experience pregnancy or perinatal loss and receive care at a NSW Health facility, including in emergency departments, maternity, gynaecology, neonatal services, perioperative services, medical imaging, allied health and outpatient clinics.

This Guideline does not include clinical management of the pregnancy or perinatal loss such as detailing medical or surgical interventions. Refer to other sources such as the [RANZCOG Clinical Guideline Miscarriage, Recurrent Miscarriage and Ectopic Pregnancy \(C-Gyn 38\)](#) and/or local guidelines and procedures for this content.

Care following sudden unexpected death in infancy (SUDI) is outside the scope of this Guideline and is covered in NSW Health Policy Directive *Management of Sudden Unexpected Death in Infancy (SUDI)* ([PD2019_035](#)).

1.1.2. Related documents

This Guideline aligns with the values and principles of respectful and supportive care following pregnancy and perinatal loss, as outlined in:

- [Care Around Stillbirth and Neonatal Death \(CASA ND\) Clinical Practice Guideline \(2024\)](#)
- [National Stillbirth Action and Implementation Plan \(2020\)](#)
- [Stillbirth Clinical Care Standard \(2022\)](#)
- [Woman-centred care: Strategic directions for Australian maternity services \(2019\)](#)
- [Connecting, listening and responding: A Blueprint for Action – Maternity Care in NSW \(2023\)](#).

1.2. Key definitions

Birth episode	<p>For the purposes of this Guideline, the birth episode is the period of time between birth and when the baby is discharged.</p> <p>This differs to the general use of this term (which relates to the maternal course) due to it being used in this document to define which neonatal deaths fall within this Guideline's scope based on the baby's admission period, which may differ from the woman's admission.</p>
Cold cot	<p>A refrigerated cot or basket that maintains a cool temperature that helps to slow down the rate of deterioration of the baby after death. It allows the family to spend an extended time with their baby.</p>
Gestation	<p>For the purposes of this Guideline, 'gestation' refers to the gestation of the pregnancy at the time of birth, not at the time of the baby's death (whether known or estimated).</p>
Livebirth	<p>A baby born alive, irrespective of gestational age (see section 3.2).</p>
Miscarriage	<p>Pregnancy loss occurring before 20 completed weeks of gestation, or of a baby less than 400 grams birthweight if gestation is unknown.</p>
Neonatal death	<p>Neonatal death is defined as a liveborn baby dying within 28 completed days of life, regardless of gestation at birth.</p> <p>Neonatal deaths within the scope of this Guideline are those which occur during the birth episode. Neonatal deaths which occur after the birth episode should be managed in line with NSW Health Policy Directive <i>Management of Sudden Unexpected Death in Infancy (SUDI)</i> (PD2019_035) or other relevant policies and guidelines.</p>

Partner	In this Guideline, the term partner is used to reflect the woman's primary support person. This may be the baby's father, a non-birthing parent, a co-parent, or any other person who provides the primary supportive role as identified by the woman. It is crucial to recognise the role of partners and families when providing care and support for pregnancy and perinatal loss.
Perinatal loss	Loss of a baby through stillbirth, neonatal death at 0-28 days of age, or termination of pregnancy at or beyond 20 weeks gestation (or with a birthweight of at least 400 grams if gestation is not known).
Pregnancy loss	Loss of a baby through miscarriage, ectopic pregnancy, or termination of pregnancy prior to 20 weeks gestation (or with a birthweight of less than 400 grams if gestation is not known).
Informed decision-making	Informed decision-making is the two-way communication process between a woman and one or more health care professionals. Women must have adequate information and time to consider their options, express preferences, make choices, and where necessary give valid consent.
Registerable birth	In Australia, all births from 20 weeks gestation onwards (or with a birthweight of at least 400 grams if gestation is not known) are registerable births, whether liveborn or stillborn. Additionally, all livebirths are registerable, irrespective of gestation or birthweight.
Stillbirth	The death of an unborn baby born at 20 or more completed weeks gestation or with a birthweight of at least 400 grams if gestation is not known.
Termination of pregnancy	The ending of a pregnancy by medication, surgical, or procedural methods, with the intention or expectation that the embryo or fetus will not survive.

Throughout this Guideline, the terms 'woman' and 'women' are used. The use of the term woman is not meant to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and identification terminology as described and guided by each individual person when providing care.

The term 'baby' is used throughout the Guideline irrespective of gestational age however it is crucial to use the preferred language as guided by the individual woman.

1.3. Legal and legislative framework

This Guideline exists within the legal or legislative context of the following documents:

- *Abortion Law Reform Act 2019* (NSW)

- *Births, Deaths and Marriages Registration Act 1995* (NSW)
- *Human Tissue Act 1983* (NSW)
- *Public Health Act 2010* (NSW)
- *Health Administration Act 1982* (NSW)
- *Coroners Act 2009* (NSW).

2. Individualised care

Care for all women, partners, and families affected by pregnancy or perinatal loss must be tailored to their individual needs and requests. Women are diverse and therefore care must be individualised to be responsive to their diverse needs. Religious, cultural, moral, and spiritual beliefs or personal wishes may all contribute to a woman's care preferences related to her loss, including, but not limited to, preferences around care elements such as investigations (including postmortem), burial or cremation arrangements, contact with the baby, and creating memories. Such requests are to be documented clearly in the woman's health record.

For women who are not fluent in English or are Deaf, effective communication and informed decision making must be supported through the use of health care interpreter services in line with NSW Health Policy Directive *Interpreters – Standard Procedures for Working with Health Care Interpreters* ([PD2017_044](#)).

Some cultural and demographic groups are statistically more likely to experience perinatal loss. Health care professionals must be aware of each woman's pregnancy and medical risk factors, history of trauma and loss, and provide care which is in line with the woman's individual needs. This includes ensuring all care aligns with relevant frameworks and guiding documents, including but not limited to:

- NSW Health [Integrated Trauma-Informed Care Framework](#)
- NSW Health [Aboriginal Health Plan 2024-2034: Sharing power in system reform](#)
- NSW Health [NSW LGBTIQ+ Health Strategy 2022-2027](#)
- NSW Health Policy Directive *Responding to the health care needs of people with disability* ([PD2024_030](#))
- NSW Health Policy Directive *NSW Plan for Healthy Culturally and Linguistically Diverse Communities: 2019-2023* ([PD2019_018](#)).

2.1. Aboriginal families

Aboriginal families are disproportionately impacted by perinatal loss. In Australia, Aboriginal and Torres Strait Islander peoples refer to grief, loss, and the healing process as Sorry Business. 'Stillbirth' may be referred to in other ways, such as having a 'Sorry Business baby' ([Safer Baby – Indigenous resources](#)) or a Star Baby. Health care professionals working with Aboriginal families need to provide culturally sensitive, safe, and responsive care, as well as ensure that appropriate referrals are made following pregnancy or perinatal loss.

It is important that all care for Aboriginal families promotes cultural safety and anti-racism in alignment with the NSW Health [Aboriginal Health Plan 2024-2034: Sharing power in system reform](#).

Care considerations for Aboriginal families must include:

- Provision of care close to home where possible (including recognising the cultural importance of Birthing on Country) and including extended family in decision-making if desired.
- Understanding that many visitors may attend; this should be accommodated as much as possible (such as by providing access to larger spaces for gathering) and the visitors made to feel welcome.
- Cultural practices such as Sorry Business. Sorry Business is an important time of mourning. It involves not only attendance at funerals but participation in other cultural events, activities, or ceremonies with the community. Considerations to support Aboriginal families at this time include:
 - Space to perform ceremonies such as a smoking ceremony and other rituals.
 - Consideration must be given to the return of the placenta for cultural reasons. See also NSW Health Policy Directive *Investigation, Review and Reporting of Perinatal Deaths* ([PD2022_046](#)) for information around placental testing and return.

See also *Care Around Stillbirth and Neonatal Death (CAsaND)* Clinical Practice Guideline – [Provision of culturally responsive bereavement care](#).

- Referral of Aboriginal families to targeted maternity services and child and family health services from the outset of pregnancy where available and appropriate, such as Aboriginal Maternal Infant Health Services (AMIHS) and Building Strong Foundations (BSF) programs where continuity of care is available. Further information about these services is available at the NSW Health website [Services for Aboriginal families](#).
 - Note that new referrals to these services within the immediate period surrounding a pregnancy or perinatal loss is out of scope for these services, unless the woman is an existing client.
 - If the woman and her family are already engaged with AMIHS/BSF, then it is strongly recommended that the service remain engaged in the provision of care for as long as required, based on level of need to enable continuity during the bereavement period.
- If Aboriginal specific services are not available, appropriate and timely referrals to an Aboriginal health worker or Aboriginal hospital liaison worker must be offered.

Culturally adapted resources for Aboriginal and Torres Strait Islander women are available through the Stillbirth Centre of Research Excellence [Bereavement Resources](#) website, and for Aboriginal and Torres Strait Islander dads who have experienced grief and loss around pregnancy at [SMS4dads – Deadly Dads Grief and Loss](#).

3. Immediate care

The immediate phase constitutes the management of the pregnancy or perinatal loss, usually involving hospital care (as an inpatient or outpatient). Sample checklists for elements of care following loss include:

- [Sample care checklist – perinatal loss ≥ 20 weeks gestation and neonatal death at any gestation](#) (appendix 7.1)
- [Sample care checklist – pregnancy loss < 20 weeks gestation](#) (appendix 7.2).

The quality of care provided by health care professionals in this phase of a pregnancy or perinatal loss is an important determinant of immediate and longer-term psychological wellbeing. Women, their partners and families may experience acute feelings of shock, disbelief and distress during this phase, magnified for some women by physical symptoms such as pain, bleeding and previous experiences of trauma and loss.

A range of evidence-based resources for parents and families who have experienced the loss of a baby are available through the Stillbirth Centre of Research Excellence [Bereavement Resources](#) website, including digital copies of the following books:

- [Early Pregnancy Loss – A guide for navigating care](#)
- [Guiding Conversations with your health care team when your baby dies](#)
- [Jiba Pepeny \(Star Baby\) Supporting your journey after losing Bub](#)

These resources also contain interactive prompts for women and families to consider what care they want or need and what things are personally or culturally important for them at this time. These considerations can then be explored together between women, families and health care professionals to inform an individualised and responsive plan of care.

The following sections discuss care considerations which are essential to the provision of quality care during this phase.

3.1. Empathetic communication

Acknowledging the loss with sensitivity, honesty, and compassion must always be offered at the outset of any interaction. All information must be timely, clear, factual, culturally appropriate and provided in a variety of formats as the woman and her family are unlikely to be able to process information immediately and therefore the ability to revisit information from previous conversations is necessary.

Families may have significant decisions to make following the loss of a baby. The decisions may include:

- timing, mode and place of birth
- the creation of mementos where appropriate (see [section 3.5](#))
- investigation options including postmortem for stillbirths or neonatal deaths (see [section 3.7](#)), and
- funeral arrangements.

Health care professionals must take care to avoid assumptions or judgements about what parents choose and how they respond to their loss and grief. Parents may need time to express a preference and health care professionals are to provide guidance and support as required. Parents should be given sufficient time to discuss options with their family members and community as needed. Opportunities must be offered for parents to revisit their decisions where possible, but information about time-critical issues (such as time to autopsy, how baby's condition may change) must be prioritised.

3.2. Location and provision of care

Environment

Physical and emotional care must be provided in a quiet, private space, irrespective of the gestation of the loss. Ideally, services have dedicated spaces available for women experiencing pregnancy or perinatal loss in any health care setting, which are also large enough to support the presence and inclusion of the woman's partner and family. The creation of such spaces should be considered in planning for new or refurbished facilities. Existing facilities without dedicated spaces, or smaller health facilities, must consider how a suitable quiet, private space can be provided within available infrastructure. Remove any unnecessary items from the room when using a non-dedicated birthing space (such as cardiotocograph, neonatal resuscitaire).

Care planning

Planning for location of care, including any treatment or intervention, labour, birth and postnatal care, needs to be part of informed decision-making and be individualised, carefully considering the woman's wishes and clinical care requirements. For example, the woman may be familiar with the staff and surroundings in the maternity service, and therefore find care in a private space within the birth suite preferable. However, for some women, care in the birth suite may cause further distress and a private space in another unit or area may be preferable.

Clinical care requirements must be considered and discussed with the woman, including access to appropriately trained health care professionals, pain relief, and specialty medical equipment. This information is crucial for informed decision-making.

If care is provided in a location where a woman and her family may hear babies crying, this must be disclosed and steps must be taken to minimise this noise, such as playing gentle music or white noise or other relevant strategies.

A multidisciplinary care plan must be developed in consultation with the woman and informed by a clinical assessment. The care plan, regardless of the woman's gestation, must consider:

- the most appropriate location of care provision (considering both the woman's wishes and clinical care requirements)
- timing of proposed care (including implications of timing of birth on whether the birth must be registered, if relevant)
- type of proposed care
- pain relief options – including during and following the loss

- options for investigations
- care following discharge
- a direct contact number for any questions or concerns after discharge (see [section 4.4](#))
- a follow-up appointment to provide results of any investigations
- recommendations for future pregnancy care, noting these may evolve based on the results of investigations and review as applicable (see [section 4.6](#)).

The care plan must be shared with the woman and documented in the health care record.

Midwifery and obstetric input

Women experiencing the loss of a baby from 14 weeks gestation onwards must have midwifery and obstetric medical officer involvement in their care, including via virtual care if not available directly. This also includes follow-up midwifery care either by face-to-face visit, virtual care, or phone call within one week of discharge with consultation and referral as indicated.

Women experiencing pregnancy loss before 14 weeks gestation should be referred to a local early pregnancy assessment service (EPAS), where available, for ongoing clinical care and bereavement support. This may include multidisciplinary support and care. Where EPAS is not available, local pathways must be in place to ensure appropriate and timely care. This may include virtual options.

Midwifery support may also be required for the woman and non-maternity health care professionals leading direct clinical care, such as providing advice to emergency department clinicians, and should be made available on request from the treating team.

3.2.1. Use of a recognised symbol

With valid consent from the woman, NSW Health facilities must use a locally agreed and communicated universal symbol (for example, a butterfly) on the doors of rooms, cot cards and health care records to indicate that there has been a pregnancy or perinatal loss. The purpose is to create awareness of the loss for all clinical and non-clinical staff who interact with the family to ensure compassionate and empathetic care and avoid miscommunication.

For pregnant women who have experienced a previous perinatal loss or loss of a child, services may also choose to adopt a symbol that can be placed on antenatal records and relevant request forms in subsequent pregnancies (such as a rainbow, to reflect being a [‘rainbow baby’](#)).

3.3. Assessment of signs of life

Assessing for signs of life at birth is important to differentiate between a stillbirth or miscarriage versus a neonatal death, unless the loss has been definitively diagnosed prior to birth. This assessment outcome impacts how a pregnancy or perinatal loss is defined, reported on, and whether or not the birth is registerable. Consider having the support of a second health care professional when assessing for signs of life.

Definitive signs of life at birth, irrespective of gestation, include the presence of one or more of the following:

- spontaneous breathing, crying or sustained gasps
- presence of a heartbeat or pulsating of the umbilical cord after birth
 - At very early gestations (see [section 3.3.1](#)), assess this sign visually, specifically a heartbeat visible through the chest wall or visible umbilical cord pulsation.
- voluntary muscle movements (especially of the arms or legs).

In babies who have died shortly before birth, fleeting reflex activity may be seen. This could include transient gasps or twitching/involuntary muscle movements. Reflexive activity observed during the first minutes following birth does not warrant classification as signs of life. It is important to provide a sensitive and compassionate explanation of reflexive movements to women and families where relevant.

3.3.1. Signs of life at very early gestations

Assessing signs of life

The assessment of signs of life for extremely preterm babies can be more challenging than the same assessment at later gestations due to the earlier stage of physiological development. Differences in lung and chest wall development prior to 24 weeks gestation mean that spontaneous breathing, crying, or sustained gasps are less likely to be present, and other signs of life ([see section 3.3](#)) become more definitive indicators.

At gestations below 22 weeks, or at gestations of 22 weeks or above where survival-focused care is not appropriate, assessment for signs of life should be undertaken discreetly, respecting the individual needs of the baby, the woman, and partner during this difficult time.

Following birth, the midwife or other attending health care professional may observe for visible signs of life while holding or wrapping the baby and handing them to the parents (if the parents wish to hold the baby). Assessment should be based on persistent, readily evident, visible signs. Listening for a heartbeat with a stethoscope or palpation of the umbilical cord is not necessary in these circumstances.

Communicating key information before and after birth

Even where there is little time for in-depth discussion prior to birth, a brief sensitive and compassionate explanation of the key points below with the woman and her partner may help to avoid misunderstanding:

- Babies born before 22 weeks gestation are small and their lungs and other organs are not developed enough for them to live after they are born. Often, they do not survive the birth process.
- Some babies who have died a few minutes before birth may show some brief reflex movements after birth. However, these do not constitute 'signs of life'. In such a case, under 20 weeks gestation, the baby's birth and death are not a registerable birth; after

20 weeks gestation, the baby would be registered as a stillbirth. If the gestation is not known, registration as a stillbirth is required if the birthweight is 400 grams or greater.

- Babies who do survive birth may continue showing signs of life for minutes or sometimes hours after birth. Appropriate comfort care will be provided during this time until the baby passes away (see [section 3.4](#)). All babies in this situation are registered as a birth and neonatal death, irrespective of gestation or birthweight.

Supporting parents through communication and observation

Following birth, it is important to include parents' observations (if they wish to share them) in discussions about the presence of signs of life. Health care professionals are to gently revisit the information about reflex movements if appropriate.

Effective communication can reduce the impact of trauma on parents, both in the short and longer term. Parents are likely to need small pieces of information repeated more than once before, during, and after birth to help them process the information.

For more information on signs of life at very early gestations, refer to the guidance and resources developed by [MBRRACE-UK](#).

3.4. Palliative care

Palliative care, also described as end-of-life care or comfort care, may be required in the context of perinatal loss in a range of circumstances:

- known prenatal diagnosis which is incompatible with life
- gestations below 22 weeks
- gestations of 22 weeks or above where survival-focused care is not appropriate
- following adverse events or unexpected findings during labour, birth, or in the immediate neonatal period leading to a life-limiting diagnosis, when the decision has been made to redirect care.

All of the principles outlined elsewhere in this Guideline remain relevant for women and families whose babies are on a palliative care pathway, with appropriate adjustment to accommodate the individualised needs of the baby and the family throughout the end-of-life period.

Providing individualised and holistic palliative care

Individualised palliative care pathways must be developed in conjunction with women and families to ensure that the care addresses the needs of the baby, the baby's parents, and family, including but not limited to:

- physical, such as symptom management and pain relief
- emotional, such as creating memories and providing support for grieving
- spiritual, such as religious ceremonies or rites
- cultural, such as family and community involvement and traditional practices.

Multidisciplinary input into palliative care supports holistic palliative care provision; this would be provided by a maternity and neonatal or paediatric care team with the support of specialist paediatric palliative care services as required, such as the [NSW Paediatric Palliative Care Programme](#).

Resources which support paediatric palliative care provision include:

- NSW Paediatric Palliative Care Programme: [Information for health professionals](#)
- *Comfort Observation & Symptom Assessment: Paediatric & Neonatal Chart (COSA: P&N)* (SMR060322)
- *Care Around Stillbirth and Neonatal Death (CASA ND) Clinical Practice Guideline* (2024): [Perinatal palliative care](#)
- The [NSW End of Life and Palliative Care Framework 2019-2024](#).

3.5. Creating memories

Creating memories of the baby can be comforting for parents and is often a vital part of their bereavement journey while also recognising their parenthood. An important role of health care professionals is to support activities appropriate to the gestation of the loss, and the woman's wishes. Parents experiencing perinatal loss through miscarriage, ectopic pregnancy or termination for any indication must be treated with the same sensitivity as any other perinatal loss. Provide adequate time for women and families to consider their options and revisit the discussion if creating memories is initially declined. All discussions and requests/decisions must be documented in the woman's health care record.

The following are suggestions for activities which may be appropriate and helpful, dependent on the pregnancy gestation and parents' wishes:

- Providing information about baby's physical features and condition (where appropriate) to support decision-making for seeing and holding the baby.
- Use of a cold cot (if available) can support families to spend more time with their baby.
- Encouraging bathing and dressing the baby (where possible), weighing, measuring, taking photos and/or creating other mementos (for example, an ID band, cot card, hand and footprints).
- Sensitively revisiting decisions about seeing, holding, and interacting with the baby if these options are initially declined.

Health care professionals must always demonstrate respectful treatment of the baby, using the language they would when examining or providing care to a liveborn baby. If appropriate, the baby's name must always be used. Services are to provide a special box, bag or envelope to hold the collected mementos.

Where collection of mementos is declined by the parents, discussion may include seeking valid consent for the option of collecting mementos for later reconsideration by the parents. These can be provided in a sealed box, bag or envelope to the family or to a trusted support person nominated by the family to hold on their behalf in the event they wish to access these in the future.

3.6. Reporting and review

All stillbirths and deaths of babies within the first 28 days of life (neonatal deaths) require review. Where applicable, perinatal deaths must be managed and reported as per NSW Health Policy Directive *Incident Management* ([PD2020_047](#)).

Further information about reporting and review processes in NSW can be found in NSW Health Policy Directive *Investigation, Review and Reporting of Perinatal Deaths* ([PD2022_046](#)).

Open disclosure must occur with the family if any aspects of clinical care were identified as potential contributors to the baby's death. The process and documentation requirements for this are as per NSW Health Policy Directive *Open Disclosure* ([PD2023_034](#)).

3.7. Initiating investigations

Investigation to determine the cause of death and identify contributing factors is important for both families and maternity services to ensure best practice and inform care in future pregnancies.

Recommended core investigations for stillbirth and neonatal death are outlined in NSW Health Policy Directive *Investigation, Review and Reporting of Perinatal Deaths* ([PD2022_046](#)).

Investigations for pregnancy loss less than 20 weeks gestation are outlined in NSW Health Policy Directive *Maternity - Management of Early Pregnancy Complications* ([PD2012_022](#)).

3.7.1. Discussions about investigations

Discussions about investigations with parents must include:

- the purpose and type of investigations available, what is involved and what information will be provided (including timeframes for results)
- that all investigations require valid parental consent and that they may change their mind about proceeding with investigations
- contact information if the parents have any further questions or concerns after discharge.

Resources to support families with these conversations and decisions include:

- [Understanding what happened to your baby – Parent brochure](#)
- [Understanding what happened to bub – Indigenous parent brochure](#)
- [Trying to find answers when your baby has died – Autopsy brochure](#)
- Australian Commission on Safety and Quality in Health Care [Tests and investigations after stillbirth](#).

The outcome of the discussion with the parents must be documented in the woman's health care record.

3.7.2. NSW Health Pathology Perinatal Postmortem Service

The [NSW Perinatal Postmortem Service](#) provides expert non-coronial perinatal postmortem services. Potential referrals to the NSW Perinatal Postmortem Service include:

- babies from 14 weeks' gestation where there is an intact fetus. This includes both registered births and those births that aren't required to be registered (see [section 4.1](#))
- neonates up to 28 days (corrected) post-partum
- placentas from registered and unregistered babies, neonatal deaths and high-risk neonates.
- placentas of unregistered babies that are not for post-mortem should be sent to local histopathology.

Refer to the NSW Perinatal Postmortem Service [information for clinicians and referrers webpage](#) for information on indication, documentation, valid consent, preparation of baby and placenta, transportation, and clinical information forms.

[Information for families](#) is to be provided, including translated information sheets as applicable.

Parents must provide valid consent prior to postmortem and will be supported through the process by the perinatal postmortem service care coordinator.

3.7.3. Coronial processes

Each local health district and specialty network must have access to health care professionals who have appropriate knowledge and education on local coronial processes for perinatal deaths. Health care professionals must seek advice from the coroner if any doubt exists as to whether a death must be referred. NSW Health Policy Directive *Coroners Cases and the Coroners Act 2009* ([PD2024_036](#)) contains information about when to refer, as well as supporting the family in cases where the baby's death is examinable by the coroner. Health care professionals must inform the family of the following coronial processes including:

- why it is needed
- where the baby will be taken to
- what will happen to the baby
- options in relation to involvement of the woman and family in the processes.

Further information can be found in NSW Health Policy Directive *Management of Sudden Unexpected Death in Infancy (SUDI)* ([PD2019_035](#)). General information about coronial processes for families can be found on the [Coroners Court NSW](#) webpage.

3.7.4. Placental histopathology

Stillbirth and neonatal death are indications for placental histological examination. Further information can be found in NSW Health Guideline *Maternity - Indications for Placental Histological Examination* ([GL2014_006](#)).

4. Subsequent care of the woman and her family

Subsequent care includes preparation for discharge, care in the community if appropriate, follow-up arrangements, and extends to planning a future pregnancy, if appropriate. Services provided by non-government organisations may provide important support throughout this time.

The following sections outline discussions and care considerations which are essential to the provision of quality care during this phase.

4.1. Birth registration

4.1.1. Birth and death registration requirements

Birth registration

Under the *Births, Deaths and Marriages Registration Act 1995* (the Registration Act) [NSW], all births must be registered within 60 days of the birth. This includes:

- Any baby born alive at any gestation (see also [section 3.3](#)).
- Stillbirth at 20 or more completed weeks gestation or at least 400 grams birthweight.

Parents are required to register the birth and can do this online.

Death registration

If a baby is born alive (at any gestation, see also [section 3.3](#)) and subsequently dies, the death must be registered with NSW Births, Deaths and Marriages and notified to the Registrar together with the cause of death in accordance with the Registration Act or alternatively reported to the coroner.

No registration of death is required for a stillbirth.

Notification of death

The NSW Health State Form *Medical Certificate of Cause of Perinatal Death (MCCPD)* (NH701028), updated in 2024, must be used in all public and private health facilities in NSW to notify the NSW Births Deaths and Marriages Registrar of any:

- Neonatal death of a baby who is born alive and dies within 28 days of birth.
- Stillbirth of a baby born at 20 weeks of pregnancy or more, or if the gestational age is unknown, a baby who weighs more than 400 grams.

It is important to note that the previous MCCPD form, prior to the 2024 update, did not include stillbirths. This is a practice change in order to notify the Registrar of the stillbirth, which requires certification of cause of fetal death. This form is not a death certificate and must not be issued to families.

4.1.2. Less than 20 weeks gestation

Women and families who have experienced a pregnancy loss before 20 weeks gestation (or have a birthweight under 400 grams where gestation is not known) of a baby who has died before birth do not need to register their baby.

A *Recognition of Early Pregnancy Loss* certificate is available if the pregnancy loss occurred before 20 weeks and in NSW. The certificate is free, and the baby can be named on the certificate, although it is not a legal document. A medical practitioner or midwife is required to complete the health care professional's declaration section of the application. Information and application forms can be found on the [Service NSW website](#).

4.2. Funerals, burials and cremations

Health care professionals have an important role in providing information to enable parents to make decisions about burial or cremation and about funeral services and other memorial options. Health services should ensure that information on local services is available to families as required. Further information about these services is available at the NSW Health website [Final arrangements of the deceased](#).

4.2.1. For babies whose birth is registered

Burial or cremation is a legal requirement for a baby whose birth is registered (see [section 4.1](#)). In most instances, these arrangements need to be made with a registered funeral director or cremation service. NSW Health maintains a publicly available [mortuary register](#) to help identify services within local areas.

Burial or cremation can be undertaken with or without a funeral service. The decision on whether to hold a funeral service or not is a personal choice for the baby's parents.

Options for burial, cremation, and funeral arrangements must be discussed with the parents and families in a clear and empathetic way. Written information must be provided and must include a range of locally available options and contact details for relevant services.

Information about [financial support](#) must be offered to parents where available and applicable.

In some cases, a short delay in the burial or cremation arrangements may occur if a postmortem is being undertaken.

4.2.2. For babies whose birth is not registered

Families may choose to arrange their own funeral service and/or cremation or burial of a baby whose birth does not require registration (see [section 4.1](#)), although there is no legal requirement to do so. Private arrangements would be at the family's expense. Where parents wish to make private arrangements, assistance is to be given to the family to complete the NSW Health State Form *Authorisation of the Release of Human Tissue to a Patient or Next of Kin* (SMR020033).

NSW Health Policy Directive *Organ and Tissue Donation, Use and Retention* ([PD2025_039](#)) addresses the use or disposal of human tissue and requirements for transportation and

burial. The policy requires that there be no public health risk associated with returning the baby's remains to the parents.

Health care professionals must provide parents with options available within their local area that are appropriate to the gestation and type of pregnancy or perinatal loss.

Alternatively, the health care facility may arrange for the disposal of the remains.

4.3. Discharge and postnatal care following discharge

The discharge process following loss requires compassion and individualisation. Discuss potential options as relevant to the context and the woman's and family's needs. This may include considerations such as timing of discharge, route for discharge (for example, to avoid leaving alongside families with live babies), and options around how the woman and family part from their baby and/or continue to interact with their baby following discharge, if appropriate (for example, through a cold cot at home or visiting options in the mortuary or funeral home).

Women must be provided with information on discharge about physical recovery, appropriate to the gestation of their loss. This information will include what to expect in terms of vaginal bleeding, lactation suppression, contraception needs, and other individualised care needs.

For women over 14 weeks gestation, the [plan of care](#) is to include consideration for midwifery in the home to advise on aspects of postnatal care and sources of support. Women must be provided with a direct contact number for any questions or concerns after discharge. Follow-up care by a midwife and/or obstetric medical officer – either by face-to-face visit or phone call – must occur within one week of discharge. Wherever possible, continuity of midwifery care is to be provided during this period.

4.4. Referral to ongoing care and support

All offers of support must be individualised to the needs of the woman and her family, be appropriate to the gestation of the loss and provided in a variety of formats.

Services must ensure that referral pathways to sources of support, such as social workers, cultural supports, psychologists and bereavement counselling are established and able to be activated early in the woman's loss journey and continue after discharge as appropriate. This includes virtual care options where appropriate. With the woman's valid consent, her maternity care provider (if appropriate) and general practitioner (GP) must be informed about the pregnancy outcome before discharge. Services must also ensure any pregnancy related appointments are cancelled.

Consider providing the following information, as appropriate, on discharge:

- leave from work entitlements
- [financial assistance](#) and returning to work
- accommodation assistance if care is away from home, including Isolated Patients Travel and Accommodation Assistance Scheme ([IPTAAS](#))
- medical certificates for partners.

After discharge, women and their families may experience feelings of isolation and have difficulty recalling information about sources of support or follow-up arrangements. Services must provide contact details for a named health care professional at the location where the perinatal loss took place. This may be a bereavement coordinator (in line with quality statement 9 of the [Stillbirth Clinical Care Standard](#)) or another health care professional who can act as a dedicated point of contact for families who have questions or seek further support.

The consumer resource [Bereavement care and support after perinatal loss – information for parents](#) provides detailed information about various sources of support. Parents are to be routinely informed about this resource.

Evidence-based resources for parents and families are also available from the Stillbirth Centre of Research Excellence website [Care and support after the loss of a baby](#).

4.4.1. Non-government organisation bereavement support

Non-government organisations have a vital role in supporting families who experience perinatal loss, both in the short and long term. This support may include information, counselling, and peer support activities, available in a variety of formats.

There are a range of non-government organisations who provide bereavement support, some specialising in early pregnancy, stillbirth or neonatal loss. Families are to be notified of organisations that provide a support service most appropriate to their circumstances. Options include (but are not limited to):

- [Red Nose Australia - Grief and Loss Support](#)
- [Bears of Hope Pregnancy & Infant Loss Support](#)
- [Still Aware](#)
- [Stillbirth Foundation Australia](#)
- [Centre of Perinatal Excellence](#)
- [Heartfelt](#)
- [Pink Elephants](#).

Services must ensure culturally specific organisations and resources are highlighted for families, if relevant and available (see also [section 2.1](#)).

Some non-government bereavement services accept referrals or handovers from health care professionals or services on behalf of women as well as self-referral from women and families. Consider offering this option to women and families. Service-led referral avoids placing responsibility on women and families to navigate seeking help and support for themselves while grieving. Service-led referrals or handovers to non-government organisations require the woman's valid consent.

4.4.2. Grief information packages

Services are required to provide women and families who experience perinatal loss with grief information packages which are individualised to their circumstances. Minimum inclusions in grief information packages include:

- normal grief reactions, including the consumer resource [Bereavement care and support after perinatal loss – information for parents](#) and relevant resources available through the Stillbirth Centre of Research Excellence [Bereavement Resources](#) website
- registering the birth and death (see [section 4.1](#))
- postmortem information (see [section 3.7.1](#))
- funerals, burials and cremation (see [section 4.2](#))
- non-government organisation websites and appropriate resources (see [section 4.4.1](#)).

Grief information packages may also include mementos such as:

- teddy bears, journals and candles
- flower seeds for the family to plant in memory of their baby

A special box, bag or envelope should be provided to hold the mementos collected as part of memory making (see [section 3.5](#)).

4.5. Follow-up care

All women and families must be provided with clear and comprehensive verbal and written information about any follow-up care before discharge. Follow-up may be provided by the woman's GP, her maternity care provider, local hospital, or tertiary referral hospital (if her care took place there) appropriate to the gestation and [plan of care](#). All women who experience perinatal loss more than 14 weeks gestation must receive follow-up midwifery care, including obstetric consultation and/or referral as appropriate.

Tiered perinatal networks must develop pathways to ensure women and their families have access to bereavement support and follow-up as close to home as possible. This may involve virtual support and follow-up arrangements for families living in regional, rural and remote areas.

All follow-up appointments must:

- be sensitive to environmental needs and triggers, for example, avoiding exposure to pregnant women in the waiting area (see location considerations in [section 3.2](#)).
- be led by a health care professional who is experienced in providing feedback to parents, preferably who is known to the parents from the immediate care episode, and is able to address their clinical and emotional needs.
- provide all available results with clear information about any delays or interim results.
- include discussions about implications for future pregnancies where appropriate, and provide the consumer resource [Reducing Risk of Stillbirth: Preparing for a healthy pregnancy and birth](#).

4.6. Care in a subsequent pregnancy

Women who have experienced a previous pregnancy or perinatal loss after 14 weeks or a neonatal death must be prioritised for a continuity of carer model as per the [National Stillbirth Action and Implementation Plan](#) recommendations.

Guidance for health care professionals about care in a subsequent pregnancy include:

- *Care Around Stillbirth and Neonatal Death (CASAND) Clinical Practice Guideline – [Care in subsequent pregnancies](#)*
- Stillbirth: the [Stillbirth Clinical Care Standard](#) (Quality Statement 10)
- Preterm birth: [Australian Preterm Birth Prevention Alliance](#)

Guidance for families about subsequent pregnancy:

- [Pregnancy After Loss – A guide for navigating your pregnancy journey](#).

5. Staff training and support

This section applies to all members of the multidisciplinary team who may provide care and/or support for women and families experiencing pregnancy or perinatal loss and for managers of these health care professionals.

5.1. Training

Evidence strongly supports the necessity of the multidisciplinary team receiving training and support for the delivery of best practice care for perinatal loss. The following elements are to inform health care professionals' practice and approach to:

- understanding grief and loss
- sensitive, appropriate, and individualised bereavement support
- awareness of relevant guidelines
- an understanding of the local care pathways and referral options available
- an understanding of how to have conversations:
 - about perinatal loss and neonatal death
 - about stillbirth and stillbirth prevention (such as the [Safer Baby Bundle eLearning](#))
 - about seeking valid consent for perinatal postmortem, as per the NSW Health Policy Directive *Non-Coronial Post Mortems* ([PD2013_051](#)) [also see the My Health Learning module – *Conversations about perinatal post-mortem*].

Completion of the [Improving Perinatal Mortality Review and Outcomes Via Education](#) (IMPROVE) eLearning educational program is recommended for all health care professionals providing bereavement care. Registration is through [My Health Learning](#) course code 338074305. Face-to-face IMPROVE training is also available.

5.2. Support

Providing care at or around the time of pregnancy or perinatal loss, in any context, is often very intense and can be distressing or triggering for health care professionals, including through episodic or cumulative vicarious trauma and/or through carrying emotional labour in excess of role expectations. This can lead to experiences of:

-
- overwhelm (such as irritability, anxiety about coming to work, difficulty concentrating)
 - compassion fatigue/empathetic distress (such as feeling emotionally numb or unable to give their normal range/level of emotional responses)
 - burn-out (such as exhaustion, cynicism, feeling distant, reduced productivity).

These experiences can impact health care professionals in their professional role and may also have flow on effects to their personal wellbeing. Health care professionals may also have lived experience of pregnancy or perinatal loss which may increase their distress.

NSW Health services must recognise the potential for significant impacts on staff and ensure that pathways of support are offered and readily available to health care professionals. This will ensure they are supported to work safely and sustainably.

This should include options such as:

- formal and informal debriefing
- peer support programs
- reflective clinical supervision
- use of the Employee Assistance Program (EAP)
- quarantined and prioritised time for engaging in these activities.

The *Care Around Stillbirth and Neonatal Death (CASA ND) Clinical Practice Guideline* (2024) includes a section on [supporting healthcare professional wellbeing](#) which contains links to other services and resources which health care professionals may benefit from accessing.

The Stillbirth Centre of Research Excellence also provides the [Caring for the Carer](#) eLearning course which supports the wellbeing of health care professionals caring for bereaved families after perinatal loss.

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7. Appendices

1. Sample care checklist – perinatal loss $\geq$ 20 weeks gestation and neonatal death at any gestation
2. Sample care checklist – pregnancy loss $<$ 20 weeks gestation

7.1. Sample care checklist – perinatal loss ≥ 20 weeks gestation and neonatal death at any gestation

Care considerations	
Care plan developed after clinical review (must include obstetric medical officer and midwife)	Yes ☐ No ☐
Documented in the health care record	Yes ☐ No ☐
Shared with family	Yes ☐ No ☐
Social worker	Accepted/contacted ☐ Declined ☐ Seen by/date _____
Spiritual needs – e.g. clergy/pastoral care, ceremonies (document discussion, requests and actions in health care record)	Accepted/contacted ☐ Declined ☐ Seen by/date _____ Comments _____
Cultural needs – e.g. Aboriginal health worker, traditional practices (document discussion, requests and actions in health care record)	Accepted/contacted ☐ Declined ☐ Seen by/date _____ Comments _____
Bereavement care resources provided	Yes ☐ Declined ☐
Culturally adapted bereavement resources provided – e.g. Aboriginal resources, translated resources	Yes ☐ Declined ☐ Not applicable ☐
Baptism/Blessing/Naming ceremony conducted	Accepted ☐ Declined ☐ Conducted by/date _____
Have parents named their baby? (leave blank if not named yet)	Yes ☐ Baby's name: _____
Have parents touched/held/viewed their baby? (note: if initially declined, revisit the option as appropriate)	Yes ☐ Declined ☐
Valid consent for Universal symbol Symbol placed on:	Yes ☐ Declined ☐
• Maternal records	Yes ☐ No ☐
• Cot Card	Yes ☐ No ☐
• Door of room	Yes ☐ No ☐
• Other (specify)	Yes ☐ _____
Baby	
Clinical examination as per CAsaND	Completed ☐
Dressed and 2 x ID bands applied	Completed ☐

Cot card	Yes ☐	Declined ☐	Not applicable ☐
Lock of hair	Yes ☐	Declined ☐	Not applicable ☐
Hand/footprints	Yes ☐	Declined ☐	Not applicable ☐
Cold cot available	Yes ☐	No ☐	Declined ☐
Photography			
Clinical photography with valid parental consent	Completed ☐		
Professional photography – e.g. Heartfelt	Accepted ☐	Arranged ☐	Declined ☐
Family photos	Accepted ☐	Declined ☐	
Photos saved on eMR and/or USB	Yes ☐		
Photos provided to parents	Yes ☐	Declined ☐	
Photos deleted from camera after saving	Yes ☐		
Reporting			
As per NSW Health Policy Directive <i>Incident Management</i> (PD2020_047)	Yes ☐	Not applicable ☐	
As per NSW Health Policy Directive <i>Investigation, Review and Reporting of Perinatal Deaths</i> (PD2022_046)	Yes ☐	Referred for later completion ☐	
Investigations			
As per NSW Health Policy Directive <i>Investigation, Review and Reporting of Perinatal Deaths</i> (PD2022_046)			
Parent information provided (see examples of available resources in section 3.7.1)	Yes ☐	No ☐	
Investigations consented (list):			
Investigations completed and date sent (list):			
Maternal investigations (list):			
Maternal investigations completed and date sent (list):			
Care Coordinator Perinatal Postmortem Service referral sent	Yes ☐	Not applicable ☐	

Placenta sent to Pathology for histological examination with detailed request form	Yes ☐	No ☐
Discussion regarding return of placenta for cultural reasons (as appropriate)	Yes ☐	No ☐ Not applicable ☐
Documentation		
Neonatal death documentation in electronic medical record under their Area Unique Identifier (AUID)	Yes ☐	Not applicable ☐
NSW Register of Congenital Conditions (added folder in electronic medical record)	Yes ☐	Not applicable ☐
Complete electronic medical record and refer for Perinatal Mortality Review completion	Yes ☐	Not applicable ☐
Non-coronial postmortem consent and authorisation SMR020.029	Yes ☐	Declined ☐
Medical certificate of cause of perinatal death (MCCPD) NH701028	Yes ☐	Not applicable ☐
Cremation Risk Advice SMR010.523	Yes ☐	Not applicable ☐
Cremation certificate SMR020.037 (stillborn/medical termination)	Yes ☐	Not applicable ☐
Medical Referee's Permit for Cremation of Body of Still-Born Child NH606570A	Yes ☐	Not applicable ☐
Authority to collect deceased form SMR020.210	Yes ☐	Not applicable ☐
Information provided on discharge		
Registration of birth and/or death information provided and discussed	Yes ☐	No ☐
Centrelink bereavement form	Yes ☐	Not applicable ☐
Funeral/burial/cremation arrangements	Yes ☐	No ☐
Aspects of postnatal care – e.g. lactation suppression, contraception	Yes ☐	No ☐
Midwifery contact within 1 week postnatal arranged – at least one of:	☐ Home visit with current model of care ☐ Home visit with Midwifery in the Home ☐ Other (specify) _____	
Clinical follow-up arrangements booked	Yes ☐	No ☐
Contact details for hospital bereavement coordinator/dedicated contact person provided Name and contact number:	Accepted ☐	Declined ☐ _____

Information provided about relevant NGO/s and/or other support resources	Accepted ☐	Declined ☐
Communication with Child and Family Health to avoid unnecessary family contact	Yes ☐	No ☐ Not applicable ☐
Communication with GP advising of pregnancy outcome and follow-up care needs	Yes ☐	No ☐

*Adapted from Murrumbidgee Local Health District Perinatal Bereavement Pathway MU110.034

7.2. Sample care checklist – pregnancy loss < 20 weeks gestation

Care considerations	
If gestation >14 weeks care plan developed after clinical review by obstetric medical officer and midwife	Yes (direct) ☐ Yes (virtual care) ☐ No ☐
Documented in the health care record	Yes ☐ No ☐
Shared with family	Yes ☐ No ☐
If gestation <14 weeks health care professional has consulted with an obstetric medical officer on admission and as indicated thereafter	Yes ☐ No ☐
Social worker	Accepted/contacted ☐ Declined ☐ Seen by/date _____
Spiritual needs – e.g. clergy/pastoral care, ceremonies (document discussion, requests and actions in health care record)	Accepted/contacted ☐ Declined ☐ Seen by/date _____ Comments _____
Cultural needs – e.g. Aboriginal health worker, traditional practices (document discussion, requests and actions in health care record)	Accepted/contacted ☐ Declined ☐ Seen by/date _____ Comments _____
Bereavement care resources provided	Yes ☐ Declined ☐
Culturally adapted bereavement resources provided – e.g. Aboriginal resources, translated resources	Yes ☐ Declined ☐ Not applicable ☐
Valid consent for Universal symbol Symbol placed on:	Yes ☐ Declined ☐
• Maternal records	Yes ☐ No ☐
• Cot Card	Yes ☐ No ☐
• Door of room	Yes ☐ No ☐
• Other (specify)	Yes ☐ _____
Depending on parental wishes, gestation, and fetal size and condition	
Have parents named their baby	Yes ☐ Baby's name: _____
Have parents touched/held/viewed their baby? (note: if initially declined, revisit the option as appropriate)	Yes ☐ Declined ☐ Not applicable ☐
Memory making photos: Photos attended	Yes ☐ Not applicable ☐

Photos saved on eMR and/or USB	Yes ☐	Not applicable ☐
Photos given to parents	Yes ☐	Not applicable ☐
Photos deleted from camera after saving	Yes ☐	Not applicable ☐
Professional photography e.g. Heartfelt	Accepted ☐ Not available ☐	Declined ☐ Not applicable ☐
Baby dressed and 2 x ID bands applied	Yes ☐	Not applicable ☐
Cot card	Yes ☐	Declined ☐ Not applicable ☐
Lock of hair	Yes ☐	Declined ☐ Not applicable ☐
Hand/footprints	Yes ☐	Declined ☐ Not applicable ☐
Reporting		
As per NSW Health Policy Directive <i>Incident Management</i> (PD2020_047)	Yes ☐	Not applicable ☐
Investigations		
Pathology/Histology requests Specify consent/completion date:	Yes ☐	Not applicable ☐
Discussion regarding return of placenta for cultural reasons (as appropriate)	Yes ☐ ☐	No ☐ Not applicable ☐
Documentation		
Agreement and arrangements for burial/cremation of unregistered baby SMR20.037	Yes ☐	Not Applicable ☐
Authorisation of the release of human tissue to a patient or next of kin SMR020.033	Yes ☐	Not Applicable ☐
Offer 'Recognition of Early Pregnancy Loss' certificate from Service NSW	Accepted ☐ Declined ☐ Not Applicable ☐	
Information provided on discharge		
Disposal of baby's remains	Yes ☐	No ☐
Private arrangements requested	Yes ☐	No ☐
Aspects of postnatal care – e.g. lactation suppression, contraception	Yes ☐	No ☐
Midwifery contact within 1 week arranged (after 14 weeks gestation only)	Yes ☐	No ☐ Not applicable ☐
Clinical follow-up arrangements	Yes ☐	No ☐
Contact details for hospital bereavement coordinator/dedicated contact person provided Name and contact number:	Accepted ☐	Declined ☐

Information provided about relevant NGO/s	Accepted ☐	Declined ☐
Communication with GP advising of pregnancy outcome and follow up care needs	Yes ☐	No ☐

*Adapted from Murrumbidgee Local Health District Miscarriage/Termination Checklist MU110.025